

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

2001 AUG 23 A 10:21

1. TRANSMITTAL NUMBER:

0 1 _ 0 1 9

2. STATE:

MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

JULY 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

1931(b)(2)(B)

42 CFR 435.1007(b)(1) & (2)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1 to Attachment 2.6-A, pgs 1, 8 and 9

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 147,443

b. FFY 2002 \$ 442,329

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

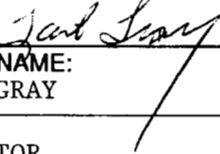
Section 1931 and Medically Needy Income Standard Increases - Annual

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

SINGLE AGENCY DIRECTOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

GAIL GRAY

14. TITLE:

DIRECTOR

15. DATE SUBMITTED:

AUGUST 16, 2001

16. RETURN TO:

DPHHS
GAIL GRAY
PO BOX 202951
HELENA MT 59620-2951
ATTN: JEAN ROBERTSON**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

August 23, 2001

18. DATE APPROVED:

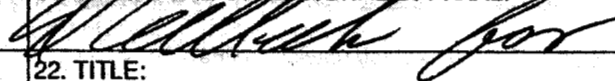
9/18/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

7/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Spencer K. Ericson

22. TITLE:

Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: August 22, 2001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Montana

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-related Groups Other Than Poverty Level Pregnant Women and Infants:

<u>Family Size</u>	<u>Need Standard</u>	<u>Maximum Payment Amount</u>
1	\$ 369	\$ 293
2	499	392
3	629	491
4	759	591
5	889	690
6	1,019	789
7	1,148	889
8	1,278	987
9	1,408	1,036
10	1,538	1,084
11	1,668	1,125
12	1,798	1,167
13	1,927	1,204
14	2,057	1,239
15	2,187	1,272
16	2,317	1,303

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percentage of the official Federal income poverty level--

X 133 percent _____ Percent (no more than 185 percent)
(specify)

TN # 01-019 Approved 09/18/01 Effective 07/01/2001
Supersedes
TN # 00-006

Revision: HCFA-PM-91-4
August 1991

(BPD) SUPPLEMENT 1 TO ATTACHMENT 2.6-A
PAGE 8

OMB No.: 938 -

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Montana

INCOME LEVELS (Continued)

D. Medically Needy

☒ Applicable to all groups.

☐ Applicable to all groups except those specified below. Excepted group income levels are listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for one month [] urban only [x] urban & rural	Amount by which column (2) exceeds limits specified in 42 CFR 435.1007*	Net income level for persons living in rural areas for _____ months	Amount by which column (4) exceeds limits specified in 42 CFR 435.1007*
1	\$ 525	\$	\$	\$
2	\$ 525	\$	\$	\$
3	\$ 658	\$	\$	\$
4	\$ 792	\$	\$	\$
For each additional person, add:	\$	\$	\$	\$

* The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Montana

INCOME LEVELS (Continued)

D. Medically Needy

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for one month [] urban only [x] urban & rural	Amount by which column (2) exceeds limits specified in 42 CFR 435.1007*	Net income level for persons living in rural areas for _____ months	Amount by which column (4) exceeds limits specified in 42 CFR 435.1007*
5	\$ 925	\$	\$	\$
6	\$ 1058	\$	\$	\$
7	\$ 1192	\$	\$	\$
8	\$ 1317	\$	\$	\$
9	\$ 1383	\$	\$	\$
10	\$ 1450	\$	\$	\$
For each additional person, add:	11 - \$ 1508 12 - \$ 1558 13 - \$ 1608 \$	14 - \$ 1658 15 - \$ 1700 16 - \$ 1742 \$	\$	\$

* The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

TN # 01-019 Approved 09/18/01 Effective 07/01/2001
Supersedes
TN # 00-006